SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

MARCH 1950

VOL. LIV No. 3

CONTENTS

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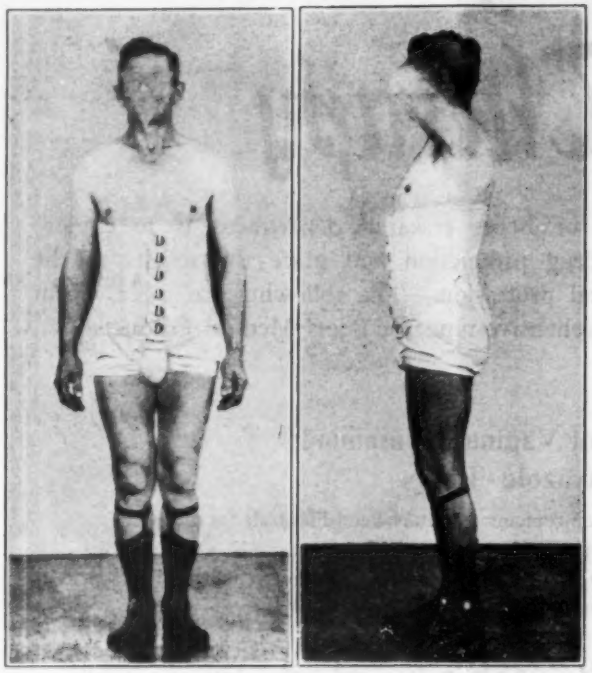

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

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JUNGLE MEDICINE?

THE days of shooting leopard from one's front verandah between ward rounds are past. But for all that, Medicine in the Colonies has lost none of its interest and fascination. The established misconception that the black sheep of the medical family is handed a rifle, stethoscope and single fare to Kenya has been replaced by dreams of heroic exploits in epidemics of plague, malaria and the like among growers of the elusive groundnut. It is perhaps necessary to point out that neither of these ideas bears any resemblance to the truth.

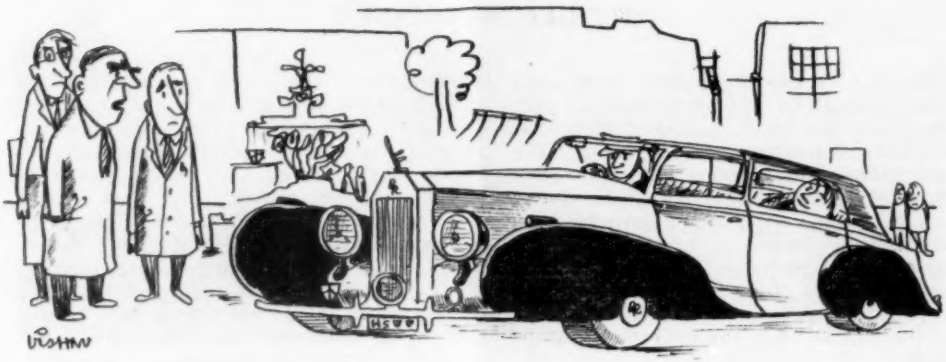
It is also commonly believed that Medicine overseas is a kaleidoscope of trypanosomiasis, bilharzia and elephantiasis, names conjuring visions of jungle, giraffe and juju. But it would be difficult to distinguish a diagnosis board in an African ward from its St. Bartholomew's counterpart — except perhaps that Christopher Columbus, George Washington and Winston Churchill require treatment more often than would appear strictly necessary. Heart failure and pneumonia, nephritis and appendicitis are as common in Broken Hill as at Bethnal Green, but additional interest is continually stimulated by the more unusual tropical diseases. Physical signs however may sometimes differ—the identification of "rose spots" on a coal-black abdomen has its diagnostic difficulties.

The great advantage of practice in the Colonies, particularly in the Colonial Medical Service — a Government - controlled National Health Service that actually runs smoothly—is the early assumption of responsibility. The young entrant, fresh and white-kneed from a house job at some vast London institution, is given a small hospital, wards, out patients, operating theatre and all, and is left to work out his own salvation with help but no pestering from the higher authorities. Where in Britain would it be possible for a man qualified but twelve months to be consultant physician, surgeon, obstetrician and medical officer of health for a thousand square miles, with the extensive practical experience that this entails? Yet this is not merely commonplace, it is routine. Thymectomies and portal shunts become, not surgical curiosities, but practical necessities: to watch, at the age of twenty-five, one's toxic goitres' pulse rates drop to normal, gastrectomies eating, arthroplasties walking, must be one of life's greatest thrills.

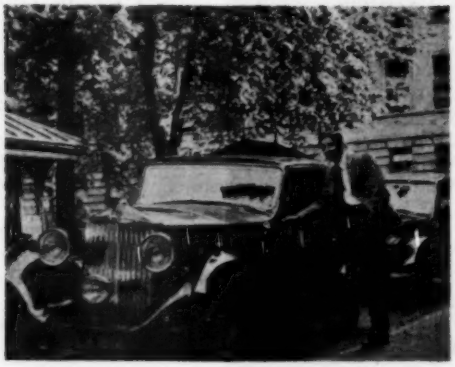
In one respect practice overseas differs markedly from the London hospital. The accustomed background of the massive phalanx of diagnostic machinery is lacking—hand and stethoscope do the work of E.C.G. and I.V.P. Except in the larger towns, elaborate diagnostic procedure is out of the question, and P.U.O.s have a habit of remaining U.

The Colonial Medical Service is not an intellectual backwater. Every facility is offered for the taking of higher examinations, with full pay and allowances whilst on study leave in England. Promotion is regular, pay adequate and an increase recently recommended, retirement pension available—a doubtful boon however in this age of devaluation.

The picture then is not entirely one of wandering nonchalantly through the jungle idly swinging a stethoscope, tapping a scrotum here, a chest there, the while wreathed in garlands by the grateful natives. It is a life of hard work—with this difference; that from the outset the results of one's labours, good or bad, are one's own. There is no "Chief" to take the credit or the blame.



"I don't care if he has won the pools. I can't have my House-surgeon turning up to Hospital like this."



YOUR PATIENT AND YOU

By Professor Sir James Paterson Ross, K.C.V.O.

An Address to the Abernethian Society

If the terms of his appointment were to be interpreted literally, the duties of a whole-time Clinical Professor would be limited to his work within his own Hospital and Medical School and to the performance of certain functions in connection with the University. In fact he is called upon to take part in a large number of extra-mural activities, and as I often feel embarrassed when I have to sacrifice some of the time which should be devoted to teaching in order to satisfy these other demands, I feel that I would like to try to make amends by passing on to you some of the ideas which have come to me in the course of these experiences outside the Hospital.

I have chosen to talk to you especially about the necessity in medical practice for understanding the individual because this subject has cropped up so frequently in so many different places and circumstances. One of my duties, for which I am ill-fitted, is to represent the Royal College of Surgeons on the Council of the National Association for Mental Health. This body devoted a two-day conference in the Spring of this year entirely to our subject, and a little later on I shall refer especially to the contribution made at that conference by Professor J. C. Spence on "The Need for Understanding the Individual as part of the Training and Function of Doctors and Nurses."

In the early summer I was a guest of the Nuffield Foundation at a conference on "Social Medicine in the Training of Medical Students." Our friends on the Foundation seemed particularly gratified to feel that at last they were doing something to interest even surgeons in social problems—but listen to this:—

> "As no two persons are exactly alike in health so neither are any two in disease; and no diagnosis is complete or exact which does not include an estimate of the personal character, or the constitution of the patient.
>
> "There used to be a French saying that 'French physicians treat the disease, English the patient.' So far as this is true it is to the honour of the English, for to treat a sick man rightly requires the diagnosis not only of the disease but of all the manner and degrees in which its supposed essential characters are modified by his personal qualities, by the mingled inheritances that converge in him, by the changes wrought in him by the conditions of his past life, and by many things besides."

That quotation is not from a contribution to our conference in 1949, but comes from Sir James Paget's address to this Society in 1885!

Another external contact, which I inherited along with many other interests from my predecessor, Professor Gask, was the privilege of serving as a Consultant to Papworth Village Settlement which, as many of you must know, was one of the first great practical experiments in Social Medicine. Papworth should always be of special interest to us because Varrier-Jones, its founder, was a Bart.'s man—one whose enthusiasm in the cause of sufferers from tuberculosis had a profound and abiding influence upon all who came to know him well.

But the consideration of the human as distinct from the scientific aspects of Medicine is continually in our thoughts—at the celebration in July of the centenary of the birth of William Osler who in spite of his many claims to fame is remembered chiefly as a great humanist; in our constant watchfulness to try to ensure that in spite of the changes brought about by the National Health Service the right personal relationship between patient and doctor may be preserved; in our endeavours to select the best candidates for admission to our Medical College; and while we watch rather anxiously the swelling of the ranks of lay assistants in our Hospitals, as the old but hallowed methods of ministering to the sick poor are replaced by the business-like organisation of modern hospital administration. It is my thesis that while change is inevitable we have no reason to suppose that it must be a change for the worse, and that it is up to us to ensure that by preserving all that was good in the past we may succeed in making it a change for the better.

Understanding the Individual

Understanding the individual is insepar-

able from clinical responsibility on the one hand and the patient's confidence in his doctor on the other. I could have chosen any of these for the title of my address but preferred "Your Patient and You," not in the sense that I anticipate for any of you so small a clientèle as the title may suggest, but because it emphasises a mental attitude which every patient expects in a good doctor —that he should behave to each patient as though he were the only one, or at least the most important person in the world at that particular moment. It is the attitude that Lord Moynihan stressed by referring to the patient as "the most important person in the theatre"—a habit of thought which comes naturally to some, can be cultivated by most, but to a few, however learned, it seems to be a matter of no interest, something not worth worrying about. Of this last group Osler writes: "A bookish man may never succeed; deep versed in books, he may not be able to use his knowledge to practical effect; or, more likely, his failure is not because he has studied books much, but because he has not studied men more"; and Professor Spence says: "They are more interested in things than in people, and they will find their place by working in laboratories or as technical therapists."

It is not my intention to try to teach you how to understand the individual patient. I am doubtful how much can be taught about such a subject by talking about it—it's rather like religion in that it is caught rather than taught, caught from those who practice it, by association with them in their own contacts with patients; yet it is not always as easy as it sounds for the student to be able to enter upon this kind of discipleship in the course of the routine medical course. Every clerk and dresser on a ward round must realise that he and the houseman have far better opportunities than his chief of finding out about the patient's private affairs. Furthermore, it must be realised that visiting the patient at home offers the best opportunity of all for understanding his background, and that this special contact has never been experienced by, and in future will be denied to many "whole-time" University teachers—surely an important argument for perpetuating and appreciating the value of the contribution made to medical education by part-time clinical teachers.

In the out-patient department as we know it the size of the classes makes the approach to the problems of the individual patient almost impossible, and we are bound to give consideration to the suggestion made and carried into effect by Professor Spence that the out-patient session should be used to instruct very small groups of students, two or three, or even single students, in the technique of a private consultation. This is so important that I wish to consider the subject in detail, but the mere thought of the reorganisation of out-patient teaching to make it possible must be enough to break the heart of any Dean!

The Art of Consultation

In order fully to comprehend Professor Spence's views on the teaching of undergraduates we must begin with the idea that there are various instruments of teaching designed to fulfil certain functions—the didactic lecture to emphasise important principles in the study and treatment of disease; the clinical lecture to dramatise an episode; ward teaching for the study of phenomena; tutorial classes to review book work; and out-patient department teaching on the art of consultation.

"The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts." It is because it falls so far short of this ideal professional relationship that many medical men find the issuing of certificates for corsets to well people an intolerable burden.

A medical man has special opportunities for assessing an individual because he sees him under the revealing circumstances of adversity. He needs clear vision, undimmed by pride or prejudice, and helped by sympathy, charity and magnanimity. The best observers of individuals and the shrewdest judges of men begin to acquire their critical faculties in childhood, among other children, especially under the guidance of wise parents, and it is for this reason that when we are selecting students for entry to the Medical College we try to find out what we can about their homes and "background."

In considering the art of consultation we may divide it into the greeting, the questioning, the examination, the diagnosis, and finally we come to the real purpose of the consultation, the explanation and advice. The first few moments of a consultation may be of the greatest importance in establishing

confidence, particularly if the patient can feel that his doctor and he have some experiences or circumstances or knowledge in common—ask about where he lives (you may know the district or you may find you have mutual acquaintances) and about his work, and get him to tell you some of the technical details, which may perhaps be of interest and importance to you, but will certainly have the effect of taking some of his attention off himself and his troubles. It is a great advantage to know something of the public services; to know, for example, that sailors don't have ranks but ratings, that there are subtle distinctions between the City and the Metropolitan Police, and that if you call a Guardsman a Private it will take you a little while to regain his respect, let alone his confidence. Children prefer a smile and a few words from the end of the bed to a sudden direct attack—bribery with pennies is a pleasant form of self-gratification rather than a help in establishing good relationships.

If you have met the patient before it is important to remember his, or especially her name, and something about her, apart altogether from her complaint. I met recently an old Bart.'s man, now a distinguished pathologist on the staff of the Medical Research Council, who told me that he regarded General Practice as the ideal form of medical service but that after he had been in practice for a few years he had been forced to give it up because he couldn't remember his patients' names. Many of us are bothered over names and have to make use of various dodges to meet the difficulty. Sir Robert Jones, who lives in memory not only because of his renown as an orthopædic specialist but because he was a very lovable man, had a series of consulting rooms in his house in Liverpool and every door had a little bracket on it into which his secretary slipped a paper before he arrived. These were not clinical records but personal memoranda, to enable him as he flitted from room to room to refresh his memory by a glance at the paper, and then to be able to add to his greeting enquiries about relations and friends. It was very flattering to think that so busy a man could remember all the little details about one of his innumerable patients—it may be a mild form of deception which is spoken of rather scornfully as a good bedside manner, or even as eye-wash, but is fully justified because it helps to gain the patient's confidence.

Any of you who clerked for Dr. Geoffrey Evans will know what I mean when I repeat his warning not to ask questions which engender self-pity or fear. After the preliminary conversation, "Well, now, tell me all about it" may be better than "What are you complaining of?" or "When were you last quite well?" And as you listen to the patient's answers to your questions, resist the popular fallacy that if the patient's demeanour is odd there must be a big element of psychological disorder underlying the whole thing and making her ill. Very often it is because a person is ill that emotional reactions are disturbed, and this you can prove by meeting the same individual again after the physical ailment has been cured and noting the return to normal behaviour. The inexperienced are often over-impressed by the influence of psychological factors: let them make quite certain about the organic elements in the disorder before assessing the importance of "a functional over-lay."

In clinical examination it is impossible to over-emphasise the importance of precision, since it is the only sure foundation for decision in giving advice. The conviction which comes from an efficient examination gains the patient's confidence more surely than anything else. It is for this reason that we lay so much stress in clinical teaching upon orderly systems of examination, repeated over and over again until after long practice all the senses are trained to make observations which are accurate and complete.

In diagnosis the first step must be the diagnosis of the disease, which can be made without taking any account of the patient's personality. This is simply a matter of naming the pathological process which can be inferred from the clinical examination, and some years ago Mr. Bernard Shaw gave a very amusing address to this Society on the risk that the orthodox medical profession was running by regarding patients as specimens of disease and not as diseased human beings. Unfortunately his address was entitled "The Advantages of Being Unregistered," and its early part was such a riot of fun that few of his hearers were able or willing to listen to the serious note on which he ended. We must all agree with Mr. Shaw's thesis that understanding the individual is a necessary adjunct to understanding the disease if the patient is to be properly treated; but the man who merely

understands the individual and particularly his weaknesses, without an understanding of disease, is well qualified to become the most outrageous charlatan.

The complete diagnosis, however, consists of three parts. First you must diagnose the disease; next you must diagnose what it means to the patient—what his conception or his fears of the disease may be; and finally you must diagnose the patient's capacity to understand your explanation of his condition and to follow your advice.

Telling the Patient

What is the patient to be told? In days gone by it was not uncommon for a patient to return home after a major operation without any idea of what had been done. This was due partly to ignorance on the part of the patients, and partly to the notion that it was as well for them not to know. Nowadays the popular Press, the broadcast and other educational influences are rapidly changing the patient's outlook and opinion on this matter, and particular attention is paid by our medical and nursing staff to seeing that the patient or the relatives are kept informed if any special danger is anticipated, and about the nature of the illness. It seems to me that if this is well done, so that those who ought to know feel they are taken fully into the doctor's confidence, only those who are mentally unstable will want to read their notes; yet we are going to a lot of trouble at the present time to prevent patients reading their notes. This must be the sole disadvantage of having notes typewritten—in days gone by there was very little chance of the patient being able to decipher the writing. The notes which ought to be concealed must form a small minority and, in my opinion, the system whereby a patient suffering from even the most benign disorder sees a sealed packet going from one department to another is sufficient to make him suspect that perhaps after all he is not being told the truth.

What *must* be kept secret is anything the patient confides to you or anything you find out about him in the course of your professional relationship with him. This is clearly laid down in the Hippocratic Oath to which we all subscribe:—

"... And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."

In this respect also there may appear to the student to be some conflict between precept or practice, because the details about a patient's private affairs are freely discussed between him and his teachers and friends inside the Hospital. We must learn that this is a very different thing from recounting them to acquaintances outside the Hospital.

Furthermore, the demands of the public for clinical details of the illnessess of distinguished people in public life is as unreasonable as it is indecent. In my opinion, although a man may be commonly exposed to the glare of publicity, he has the same right as anyone else to privacy when he is ill.

Many patients like to be told the exact diagnosis because it flatters them to hear long names; but every one wants to know what his illness is going to mean to him in terms of his living as well as of his life. Of course he wants to know if he is going to get well, but to most people it is of the first importance for them to know whether they are going to be fit to return to their proper job or not. If an operation is contemplated he must be given a general idea of what it involves, how much pain and how much disability he is to expect afterwards and for how long. The anæsthetic is an anxiety to very many patients whose fears can often be allayed by a simple and frank discussion of the methods and the risks involved. Sometimes one has the feeling that there is still some cause for anxiety in the patient's mind after all the obvious things have been mentioned. Don't say "Really, you know, you have nothing to worry about," but "I feel you still have something on your mind—tell me what it is," and it often turns out to be some quite trivial or even imaginary fear which can be dispelled by frank and open discussion. Rarely it happens that in spite of all your candour and your most patient explanations you can tell that the patient still suspects that there is some dread secret which you are keeping from him—these are the poor souls who cannot trust you because they have never known what it is to have faith in anything or anybody.

What is the patient to be told if you believe his disease to be incurable? This is a question that cannot be answered by any sweeping generalisation, because every individual must be treated as a special problem. I would only warn you to be sure

beyond peradventure before you tell a patient or his relatives that he is not going to recover —we must all have met the " octogeranium " whose mother was told by the specialist that he would never see his seventh or his fourteenth birthday! Circumstantial evidence is not always good enough to justify the diagnosis of malignant disease, and if you are suspicious enough to feel that the relatives ought to be warned, take care in such a case to indicate to them that there is a real hope of your being mistaken.

Another guiding principle is that the patient has a right to know what the outlook is provided he asks about it, but there is no reason to ram bad news down his throat. In my experience a large proportion of those afflicted by incurable malignant disease do not seem to want to be told about it, for they either know already or there is some merciful mechanism which dulls their comprehension and enables them to accept the inevitable without worrying about it. When a patient asks for the verdict it is not permissible to lie to him in order to keep him in ignorance, though it is possible, by taking care to choose the right expressions, to spare his feelings; and whether you tell him the whole truth or only part of it must depend upon your assessment of the individual and the effect it may have upon him. He may need to know in order to attend to his material affairs, and he may need to know for the good of his soul.

When we were working at St. Albans we made friends with some of the Cathedral clergy who were very interested in trying to establish closer collaboration between the priest and the doctor in the care of the sick. It must be recognised that many religious people regard sickness as sin—they consider that anyone who fails to live his life fully to the glory of God is guilty of sin, and because illness makes one fall short of this full life of service it is, therefore, sinful. Such thoughts can interfere seriously with a patient's peace of mind, and the comfort which a priest can afford may be of great benefit. It struck me in our discussions with our friends at St. Albans that some of them were more interested in helping a few patients to die properly than in encouraging the majority to live properly; for I am quite sure that the parishioner who is, for the time being, a patient can derive great benefit from the co-operation of his parson and his doctor, provided they have the inclination and the opportunity to work together.

Collaboration of Specialists

Illness can bring disaster into life which tries the courage and the spirit of the most faithful and stouthearted but a good doctor can minister not only to the physical and mental but also to the spiritual needs of his patient so as to help him through his fiery trial. The suggestion that in this task he may be assisted by an understanding priest opens up the whole question of the possibility of sharing the responsibility for the welfare of a patient, and I must say at once that while it is frequently necessary to call upon colleagues and other helpers for their expert advice or special assistance, the patient's own doctor must be his mainstay, and is in fact indispensable to co-ordinate the activities of the others.

In theory it should be possible for a patient to trust a Hospital, but in practice he sticks obstinately to his belief in one doctor rather than in the whole complicated organization which is provided to share the responsibility for his treatment. The development of the many social welfare services which have been added in recent years has tended to interfere to some extent with the old relationship which existed between a patient and a particular member of the staff, and the Ward Sister, as being the only people to whom he needed to apply for anything and everything he required. You must have heard many amusing but rather startling stories about the avarice of great consultants. There is the classical one about the surgeon who when asked how he came to have such an extraordinary fee replied that it was all the patient's relatives had in the house; and when pressed still further to explain the odd 3½d. said, " Oh, that came out of the child's money box." Quite recently I heard the other side of that story from one of that same man's old House Surgeons. Sometimes in the course of a ward round he would be touched by the sorry plight of some poor wretch who was being sent home to die, perhaps of cancer of the rectum, and as the firm moved on to the next ward he would tell the House Surgeon to take the men on for a few minutes while he slipped back to give Sister a fiver and tell her to try and get the woman something to make her more comfortable.

In those days the Ward Sister had to do the work which is now carried on much more extensively by the Almoners, and it would be impossible now for the Sisters to attend to all the details which are seen to

by the Dietitian, the Almoner, the Resettlement Officer, and the Psychiatric Social Worker. On the other hand it must be recognised that these special services can provide greater efficiency only if they are properly co-ordinated, and this function must still be undertaken by the Physician or Surgeon under whose care the patient was admitted to Hospital. There is a real risk of failure to achieve our main objective if too great a share of the responsibility is unloaded on to the shoulders of these able and willing and most valuable aides.

One Man's Responsibility

Thinking along the same line brings us to the "One - patient - one - doctor" principle which is the foundation of professional etiquette. With the growth of specialization there is a tendency for the patient to be referred rather light-heartedly from one department to another, without considering the importance of his remaining primarily under the care of one member of the Hospital Staff. It is of course essential that expert advice and skill should be sought whenever they are needed, but the responsibility for the final weighing up of the evidence and the decision about treatment should rest with one man. Furthermore I think it should be accepted as a rule that whenever a patient returns to the Hospital with the same complaint he should return to the care of the same member of the Staff, because he is bound to feel that the Firm that looked after him before must know more about him than strangers. In order to facilitate the working of that rule the patient is given a coloured card to get him back easily to the same Firm and I hope it may be a very long time before Firm colours are abandoned. Recently there has been a move to regard the coloured cards as being of minor importance, and even with the help of this system the number and variety of cards which some patients manage to collect in the course of a year or two is quite surprising, and deplorable.

The sense of personal responsibility for a patient's welfare and perhaps for his life may often give rise to anxiety—a clinincal concern which is quite distinct from administrative responsibility. This is illustrated by an incident in the wardroom of a great Naval Hospital where three Senior Officers were sitting behind newspapers after a forenoon of office work. In came a harassed young Surgeon Lieutenant with his thoughts so full of his latest clinical problem that he was thinking aloud—"What *can* one do for tuberculous meningitis?" The three newspapers came down as one, "Put him on the D.I. List!"—quite simple, no questions in the House, every reasonable precaution taken. For the anxious clinician it is often difficult to combat ineffective worry, but in my experience people worry because they are not sure of their observations, and the best remedy is to make the most precise examination that is within your power, then to decide exactly what is to be done, and finally to let the matter rest till the time of your next visit. It is, of course, harder to do this when you have had to decide to take no immediate action, for to follow the oldest inhabitant's advice to "Do good if you can, but do zummat" is an effective placebo, at least for the therapist.

In conclusion let us return to our title, "Your Patient and You." If you ever feel inclined to examine yourself to see whether you are treating your patient with proper consideration all you need to do is to imagine yourself in his place. This illness which to you is merely another "case" is to him an event of the first importance and may mean an upheaval if not a calamity in his career. His admission to Hospital is an experience which may have the most profound effect upon the relationships between himself and his fellow men, and the operation which to you is just No. x on the list is to him a milestone in his whole life. It doesn't really call for much exercise of imagination to stir our humanity and evoke our compassion. And if we do try to understand our patients as individuals what recompense are we to expect in return for our trouble? It may be that the answer to this question can be learnt only from experience, but in part it is to be found in the closing sentences of the Oration Lord Moynihan gave to the Medical Society of London in 1926.

"The surgeon may in some degree share his responsibilities with others, but the chief responsibility must always lie with him, and being his must be exercised not only during the operation but also before, perhaps long before, and also after, perhaps long after, the operation is performed. The operation itself is but one incident, no doubt the most dramatic, yet still only one in the long series of events which must stretch between illness and recovery. The patient, passing through the deep waters, may find them chill and bitter, but the thought of our labour in his service, when the toilsome days are ended, will lie as a glowing coal at his heart."

SOME RANDOM REMINISCENCES OF ANAESTHETIC PRACTICE IN AFRICA

By JOHN A. CARMAN, E.A. Medical Service.

TWENTY-FIVE years ago when there was already an efficient body of men of the Colonial Medical Service working in Kenya and a number of unofficial doctors were established in practice, the only anæsthetics in use were chloroform and ethyl chloride. It is true that a few bold spirits sometimes diluted their chloroform with more or less ether, but it was in fact upon the chloroform that they relied. It was universally held that ether could not be used at the altitude (5,600 feet) of Nairobi, just as a host of other unconnected phenomena, from free capillary oozing at operation, to inability to concentrate upon one's work after a late night, were attributed to the same cause. The tropical temperature was also blamed for the inefficiency of the drug, though shade temperatures in Nairobi seldom, if ever, reach 90°F.

It is very difficult to believe, but this condition of things went on for another 10 years. There was still no one either in the Service or outside it who gave more than superficial thought to the subject of anæsthetics and it is literally true that if a small abscess had to be opened, or a kidney required to be removed, the anæsthetic was the same, open chloroform on a lint mask. The only exception to this rule was that in some cases spinals were given for abdominal work or lower limb amputations. At the hospitals in Nairobi which were as they still are, the largest in the Colony, if an operation was decided upon, it was usual to call for the most junior medical officer available to give the anæsthetic and, of course, he never saw the patient either before or after and it would have been as much as his job was worth to suggest giving any form of anæsthesia other than that decided upon by the surgeon.

On one occasion in 1928 the writer was called upon in this way to give an anæsthetic to an obese patient for a nephrectomy. The surgeon, who never had an assistant, was methodical and slow; he was also very fussy about asepsis. His prospective anæsthetist had a biggish spot on the back of his neck with a yellow head to it and he asked the theatre sister to dab it with iodine so as to forestall critical comment by the surgeon. In mistake, the sister gave the spot a good hard rub with iodised phenol. I leave you to imagine the severe discomfort that had to be endured through three long hours while the surgeon removed that kidney. Both hands completely occupied the whole time holding up the chin of a fat woman on her side in the kidney position, with a sensation like a red-hot poker being pushed into the back of his neck. The resultant ulcer took a month to heal. But there was the other side as well. Sudden illness in his family caused the young M.O. some considerable financial embarrassment. The surgeon saw that something was on his mind and got the truth out of him. He offered a loan which was declined with grateful thanks but he was not to be beaten in his kind endeavour. He collected some seven or eight children, all of whom required tonsillectomy, arranged their operations on a single morning and called upon the writer to give the anæsthetics. He then wrote a cheque for all their fees in advance and handed it to him without comment. Such were the vicissitudes of Colonial life in the twenties when everyone knew everyone else and his joys and his troubles too. Alas! Nairobi has grown beyond all recognition. A Royal Duke is to raise her to City status next March and the old days of universal cameraderie are gone never to return.

In 1933 the question of anæsthesia became acute, at least so far as the Native Hospital was concerned. There was no one available to do this work who was even superficially competent. On his return from leave in England in November the writer went, as was the custom, to present his compliments to the Director of Medical Services and receive orders. He was greeted cordially and then almost in the same breath came the query, "Can you give anæsthetics?" to which the reply was given, "I could in years gone by but I have had no recent experience." Then came the order to report to the next senior pundit who asked the same question, still without any explanation and passed the wondering junior on to the Senior Medical Officer in charge of the Native Hospital. As was to be expected he also asked about anæsthetics but he too was the sort of person of whom one did not ask questions and eventually one arrived at the level of the surgeon. This was Mr. C. V. Braimbridge and he explained that for months the government had been paying

a local doctor to give all the anæsthetics and this accounted, as they say, for the milk in the coconut. So began a long and pleasant professional association, which has continued to the present day, for soon afterwards there was a change in Directorship and the importance of continuity in key positions was recognised. As a result of this new policy the confidence of Africans in European medicine was greatly enhanced and their fear of hospital and surgery evaporated in a surprising way. It was not very long before the number of patients in hospital exceeded the number of beds and the theatre was working to capacity to get through the cases which required operation. It may well be imagined that in such a field it was not very difficult to gain wide experience. The European community was, at this time, undergoing a phase of rapid expansion and was beginning to include increasing numbers of people who could not afford to go to Europe if they needed a major operation. Two private practitioners had by now imported anæsthetic machines but the view of the "high-ups" in the Medical Department was that what had sufficed for them in their young days was good enough for their junior colleagues. Chloroform was still the universal stand-by though it was now more commonly diluted with ether, a practice which although it gave the anæsthetist a feeling of security, was in fact so dangerous that it should have had the reverse effect. At high altitudes and raised temperatures, ether evaporates so rapidly from a mask, that before long the gauze becomes saturated with what is virtually pure chloroform, however little of that drug is contained in the original mixture. Pure chloroform, if it is carefully given, has its dangers, but if it is given under the mistaken notion that it is two thirds ether, then indeed those same dangers become acute.

It was at this stage that the writer was asked, or rather ordered, to take up the study of anæsthetics as a specialty and in spite of all protests on his part he had to do as he was told. There was no apparatus except a Shipway and an antiquated Clover with a perished bag and, of course, endotracheal tubes were quite unknown. Anæsthetic deaths were all too frequent and the impact upon the nervous system of the surgeon, of the everlasting interruptions to operations while artificial respiration was instituted to restore the patient, added seriously to the strain of long days in theatre under primitive conditions.

The first stage in the game was to overcome the prejudice against ether, for it seemed to be certain that the two factors of altitude and temperature could act in only one way, namely by increasing the volatility of the drug, thus making it easier to obtain the necessary concentration under the mask. All that was required was to wrap the mask and the patient's face in a towel and watch carefully to prevent moisture freezing on the exposed area of gauze. This difficulty was soon overcome when the surgeon found that he got all he wanted in spite of the absence of his beloved chloroform and also without the need for frequent resuscitation. There remained the lack of apparatus and on this point Officialdom remained adamant. We did, however, persaude them to let us buy a laryngoscope and some Magill's catheters, so we made an apparatus out of a couple of bits of wood, some glass bottles, rubber and glass tubing. It was a formidable machine but it was practical since every sort of case was tackled with it, even lobectomy with positive pressure. It embodied a mercury manometer and a mercury safety blow-off and was used with compressed air. Two locomotive cylinders were begged from the Railway and joined by a wide-bore steel tube to make a container. Into this were welded a small brass tap for the outlet and a motor car tyre valve for inlet. It was pumped up with a large garage-type car pump and would last for several hours. One shudders to think when one reads of the dire results of CO_2 excess, what went on in the patients' systems and, of course, the resistance to respiration must have been considerable through narrow-bore rubber tubing However, endotracheal anæsthesia was an established possibility and before long a metal machine was designed and made under close supervision by an Indian engineer. We were very proud of this apparatus which, though it still had glass bottles and rubber tubing, was easily portable and it even had a CO_2 sparklet attachment fixed to one end of its hot water container. This had subsequently to be discarded. It was apt to blow out its rubber washer with a shattering bang and since it gave no warning before doing so, the surgeon said it was more than he could stand and the thing was an unnecessary refinement anyhow. After that the patients still got their CO_2 unbeknown to him through a "T" junction in the delivery tube and a sparklet resuscitator.

In 1936 the great day came when at last the authorities yielded to persuasion and consented to the purchase of modern orthodox apparatus and today in Nairobi and in several of the other larger centres up-to-date machines are in constant use. All the old theories have been exploded. Ether is used even on the Coast, nitrous oxide and cyclopropane are also in daily use and though it is admittedly more difficult to give smooth gas and oxygen at high altitudes, it can be done with suitable premedication and close attention at every stage of the administration.

Intravenous anæsthesia was introduced here almost as soon as it was in England and the recent relaxant drugs like d-tubo-curarine chloride, C 10 and flaxedil are all used to bring to patient and surgeon alike, the advantages which are enjoyed in more advanced centres of learning at Home.

One is often asked if the African is more difficult to handle under anæsthetics than is the European. The answer is two-fold. If he has confidence in the surgeon and the anæsthetist, he is far easier to deal with. Having no idea of what lies before him, being something of a fatalist and being possessed of a very limited imagination, he does exactly as he is told and goes to sleep, often without any conscious or unconscious struggling. If, however, he cannot be brought to a state of reliance upon his doctors, the position is very different and he becomes as difficult a problem to tackle as an intoxicated dock labourer from Limehouse. Not only is he resistant during induction but he continues to give cause for anxiety throughout maintenance, having exhausted his strength by violent struggling and, of course, by reason of his excessive fear, filled his blood-stream with large quantities of adrenaline. This may not add up to serious danger in the case of robust adult males but when the patient is a weedy, under-nourished woman, the position is very much more hazardous. African women still lag far behind the men in their contacts with civilization and in their knowledge of the benefits to be obtained from western medicine. They often strenuously resist the efforts of both doctors and nurses to persuade them of the necessity for even life-saving operations and not infrequently they only consent when ordered to do so by their more sophisticated male relatives. These are cases to beware for they are quite devoid of confidence and are literally petrified with fright. It may well be argued that basal narcosis would overcome this difficulty but in a noisy African ward full of screaming children and staffed by natives, most of whom are only partially trained, this refinement is quite out of the question. They just lie there shivering with fright until they are taken to the theatre. All too often in the past the result was a tragedy and it is now forbidden that any African woman shall be over-persuaded to undergo a major operation if she is set against it.

This, which in common with numbers of others, is a lesson learned in the light of bitter experience over many years and tens of thousands of cases, has its bearing upon the art of anæsthesia wherever it may be practised and I may perhaps be forgiven if in closing I make reference to it. Time spent in reassuring patients before they face what to us is commonplace but to them may well be the most terrifying experience to which they will ever be called upon to submit, is time well spent indeed. No amount of pre- or post-operative drugging can replace the calm that comes of confidence and a mind relieved of fear. Your women patients will not die of fright like their African sisters but they will certainly do better if they face their ordeal with calm spirits. An anæsthetist, be he never so skilled and knowledgeable in such matters as partial pressures of gases and the structural formulæ of the ultra-rapid-acting barbiturates, will fail to get the best results if he is not in addition something of a psychologist and one who will take the trouble to exert his personality for the benefit of his patients, before he connects their respiratory tracts up with the most complicated and expensive machine yet devised by the ingenuity of man.

11th DECENNIAL CLUB

The next Dinner of the 11th Decennial Club will be held at Frascati's Restaurant, on Friday, April 28. Will any who do not receive a card and wish to come communicate with F. C. W. Capps, 16, Park Square East, N.W.1.

GIFFARD'S MANOEUVRE ?

By C. P. WENDELL-SMITH

A RECENT article on William Giffard contained references to the Mauriceau-Smellie-Veit method of delivering the aftercoming head in breech presentations. It concluded that credit should be given to Giffard for describing it; this is acceptable, but the reasons given for reaching this conclusion are not.

As is so common in the history of medicine, the manœuvre, as we know it today, was not suddenly discovered but was evolved over a period of years by a process of trial and error, adaptation and modification. Let us consider its genealogy.

In 1668 Francois Mauriceau's book, *Des Maladies des Femmes Grosses*, was published. Hugh Chamberlen translated it into English and it is from his translation (6th edition) that the following passage is taken:

" . . . he must disengage it, by little and little, from the Bones of the Passage, with the Fingers of each Hand, sliding them on each side opposite the one to the other, sometimes above, sometimes under, until the Work be ended, endeavouring to dispatch it as soon as possible, lest the Child be suffocated."

Lib. II. Chap. XIV. p. 187.

It will be noted that there is no mention of jaw-flexion with shoulder-traction.

Between the writing of this book and 1675, Mauriceau must have experimented, for in his second edition, published that year, he advocates the introduction of a finger into the mouth to assist in delivery of the chin. This is only the first stage in the evolution of the method, for Mauriceau did not then advise shoulder-traction with the jaw-flexion. Neither this second edition nor subsequent editions were translated into English, all the editions of Chamberlen's translation being based on Mauriceau's first edition.

Further experimentation is indicated by this quotation from the third edition published in 1681:

" . . . il ne faut pas s'amuser à tirer seulement l'enfant par les épaules: car quelquefois on feroit plutost quitter & separer le col que de l'avoir ainsi, mais durant que quelqu'autre personne tirera mediocrement le corps de l'enfant, le tenant par les deux pieds, ou au dessus des genoux, le Chirurgien dégagera peu à peu la teste d'entre les os du passage: ce qu'il fera en glissant doucement un ou deux doigts de sa main gauche dans la bouche de l'enfant, pour en dégager premierement le menton, & de sa main droite il en embrassera le derriere du col de l'enfant, au dessus de ses épaules, pour le tirer ensuite, avec l'aide d'un des doigts de sa main gauche, mis dans la bouche de l'enfant comme je viens de dire, pour en dégager le menton."

Livre II, Chap. XIII, p. 275.

[He must not content himself solely with pulling the child by the shoulders: because sometimes one would rather abandon the attempt and decapitate than do this, but while *another person* is gently pulling the body of the child, holding it by the two feet or above the knees, the Surgeon will guide the head through the bones of the passage, which he will do by gently sliding one or two fingers of his left hand into the mouth of the child in order first to free the chin, and with his right hand he will grasp the back of the child's neck above the shoulders in order to pull afterwards, with the help of one of the fingers of his left hand, placed in the child's mouth, as I describe, in order to disengage the chin.]

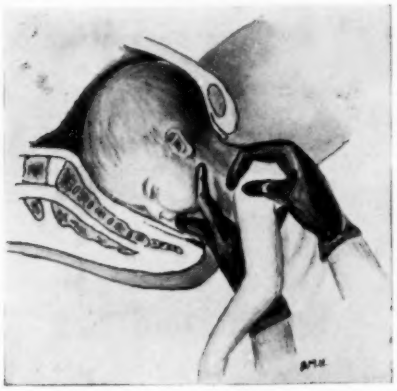
Again it is important to note that Mauriceau, with his many pupils and disciples used an assistant (" quelqu'autre personne ") in his method.

Clearly such a method, needing an assistant, was not suitable for the lone practitioner, and it remained for William Giffard, who *was* such a man, to describe his method of delivery *without* an assistant. One of his cases delivered by this method is described in the article mentioned above. Also in that article, the author states that, in his opinion, Giffard did not know Mauriceau's views, " because he did not, *at first*, realise the importance of delivering the head with the face of the child turned towards the sacrum, an essential point stressed by Mauriceau." It may be that Giffard did *not* know of Mauriceau's views, but he *did* realise the importance of turning the face towards the sacrum, and did so early in his career; for of the second case in his book, dated January 25, 1725, he writes:

" Upon examination after the Delivery, I found the Head pressed very flat, and the Coronal Suture riding above an inch: this I judged, in great measure, to proceed from the unhappy situation of the Child; for it came sideways with the Face towards the Hip: the Head was so locked in the Passage by the long continuance in this Posture, that I was not able, with all my strength, to turn the Face towards the Buttocks."

Case II, p. 5.

The child was dead when Giffard arrived, having "come forth, with the Feet foremost, as far as the Buttocks, in which Posture it had stuck for about two hours." He delivered by jaw-flexion with shoulder-traction, but in doing so broke the child's jaw.



Jaw-flexion with Shoulder-traction.

From Giffard we pass to Smellie, who taught Giffard's methods and recommended students to read his book. Such a great teacher as Smellie must certainly have popularised the manœuvre. In his *Treatise* (4th edition, 1762) Smellie says:

"If one finger of his right hand be fixed in the child's mouth, let the body rest on that arm; let him place the left hand above the shoulders and put a finger on each side of the neck: if the forehead is towards one side at the upper part of the Pelvis, let him pull it lower down, and gradually turn it into the hollow of the Sacrum; then stand up, and, in pulling, raise the body so as to bring out the head in an half-round turn, as above directed."

Vol. I, Chap. IV, Sect. II, p. 312.

There remains the contribution of Veit. Aloys Constantin Conrad Gustav Veit published a paper called "Ueber die beste Methode zur Extract des nachfolg Kindes kopfer," in the *Greifswalder med. Beiträge* of 1863. This obscure publication of the Greifswalder medical faculty was only issued from 1863 to 1865, and is very rare; the only readily traceable copy being in the library of the Surgeon-General's Office in Washington. In the *Biographisches Lexikon* of Dr. August Hirsch, concerning this paper, we read:

"Heir beschreibt er den nach ihm und *Smellie* genannten Handgriff zur Extraction des Kopfes bei schon geborenem Rumpf."

[Here he describes the grip named after him and Smellie, for the extraction of the head when the breech is already born.]

Fasbender endorses this. It appears that Veit primarily popularised the method in Germany, doubtless with the aid of his son Johann, editor of the famous "*Handbook der Gynäkologie.*

Thus unfolds the story of jaw-flexion with shoulder-traction, a manœuvre which must be credited not to one man, nor to the more usual three, but to all concerned in its development. An attempt at tracing and clarifying this evolution has been made and it is hoped that some misconceptions have been corrected.

Thanks are expressed to Mr. W. J. Bishop of the Wellcome Medical Library and Mr. J. L. Thornton of St. Bartholomew's Hospital College Library for help and for access to the original works quoted in this article, also to Dr. Wilfred Shaw and Messrs. J. and A. Churchill Ltd. for permission to use the illustration from Dr. Shaw's *Textbook of Midwifery*.

BIBLIOGRAPHY

Giffard, W. *Cases in Midwifry*, London, 1734.

Mauriceau, F. *Des Maladies des Femmes Grosses*, Paris 1668. *Traite' des Maladies des Femmes Grosses*, Paris, 1675. *Traite' des Maladies des Femmes Grosses*, Paris, 1681. *The Diseases of Women with Child*, translated by H. Chamberlen, 6th Edition, London, 1727.

Radcliffe, W. "William Giffard, Man-Midwife," *St. Bart. Hosp. J.*, Vol. LIV, 1950, pp. 37-40.

Smellie, W. *Treatise on the Theory and Practice of Midwifery*, 4th Edition, London, 1762.

PHYSICIAN TO THE KING'S HOUSEHOLD

Dr. R. Bodley Scott was appointed Physician to the King's Household on December 13, 1949.

We wish him success in his new appointment.

1. WILLIAM HARVEY; c. 1622, aet. 45.
Formerly at Rolls Park, Essex.

2. WILLIAM HARVEY; c. 1655, aet. 78.
Hunterian Collection, University of Glasgow.

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WILLIAM HARVEY; MAN AND IMAGE

The Portraiture of William Harvey, by Geoffrey Keynes. London, R.C.S., 1949. 25s.
The Personality of William Harvey, by Geoffrey Keynes. Cambridge, 1949. 5s.

WILLIAM HARVEY was born in 1578, the eldest of seven sons of Thomas Harvey, yeoman, of Folkestone, and was educated at the King's School, Canterbury, and Caius College, Cambridge. Padua gave him his training and his doctorate, and the friendship of Fabricius. Returning to England in 1602, he began to work in London: his marriage in St. Sepulchre's to Elizabeth Browne, whose father was physician to Queen Elizabeth and King James, foreshadowed his lifelong connection with St. Bartholomew's and with the Court. His professional career was rapid, and in 1616 he was appointed Lumleian Lecturer in Anatomy to the College of Physicians. His MS notes for these lectures show that he had by then become convinced of the circulation of the blood. The publication of *De Motu Cordis*, Frankfurt, 1628; *De Circulatione Sanguinis*, Rotterdam and Cambridge, 1649; and the first English tranlation, London, 1653, reflects the gradual acceptance, scarcely complete at his death, of a discovery too great to merit polemics.

Harvey was appointed Physician to this hospital in 1609, and held the post for 34 years: he did not live on the precincts, and received an extra £8 6s. 8d. on that account. He made vigorous and sensible suggestions for reforms, which were adopted by the Governors—who seem to have appreciated his worth. The surgeons, by contrast, became restive at his repeated absence from his duties: he accompanied King Charles on many of his journeys, and was with him, and made Warden of Merton, during the last stand of the Civil War. The next year he retired, and lived quietly till his death in 1657. He was even unwilling to allow his friend Dr. Ent to publish the *De Generatione Animalium* (London, 1651), which has earned him the title of Father of British Midwifery.

What kind of a man was this that turned the mediæval rite of medicine into an experimental science, whose fame is such that he has even been identified with the mysterious W. H. of Shakespeare's Sonnets? Mr. Keynes' two books, in succession to his *Biblography* (1928) and tercentenary edition of *De Motu Cordis* (1928), give the answer. The first was the Vicary Lecture for 1948 to the Royal College of Surgeons, who have published it handsomely. It is an analysis and critical comparison of the extant representations of Harvey, conducted with taste and skill, and with that discerning eye for details of face and dress, of eyebrow and tassel, which reveals derivations and exposes errors: the conclusion that few contemporary portraits exist may be unwelcome, but is shown to be inevitable. The earliest and best (Fig. 1), which shows a dark and fervid young man and is inscribed *Docter William Harvey*, has for long been strangely overlooked, and an account of its recognition and preservation forms an apendix to the Lecture. It was one of a group of portraits of Thomas Harvey and his sons set in the wall of a house that has remained in the possession of the descendants of Eliab Harvey; Sir D'Arcy Power saw the pictures in 1928, and had a photograph of them which is now in the Library, but he thought they were posthumous. Mr. Keynes dates this important likeness 1620-1625. Thirty years later there is dignity and wisdom, besides an alert impatience, in the portrait attributed to Bemmel (Fig. 2). This seems a more honest delineation of character than the "State Portrait" at the Royal College of Physicians, which has been the source of most of the subsequent copies and engravings (although as early as the 18th century one of these, a mezzotint by MacArdell, was remote enough from the original to give rise to the plausible supposition that a portrait by Van Dyck had existed). These three pictures, with the memorial bust by Edward Marshall at Hempstead, and engravings by Faithorne and Gaywood, allow the construction of a very clear image of Harvey. Two of the portraits, and the bust at Hempstead, bear the arms granted to Sir Daniel Harvey in 1660 quartered with those of Sir Walter Hervey, Mayor of London in 1272, and in one case the motto PIV ARDE PIV SPLENDE, and crest, a torch with serpents twined about it; this crest is also seen at Padua as Harvey's *stemma* or memorial. William Harvey was no more proud than prophetic, and it seems likely that these trappings are at least partly a later product of that strong family sense which is as conspicuous among the Harveys as their physical resemblance.

On his study of Harvey's appearance and the few contemporary comments Mr. Keynes based his Linacre Lecture at Cambridge last May. It is a delightful evocation of an attractive personality, enquiring, zestful, modest, devoted to the rational investigation of Nature; similar in some respects to that of John Hunter, but more polished. Aubrey's stories that he held Man to be "but a great mischievous baboon," and that he kept an opiate ready to ease his death both ring true, and his religious outlook was unusually broad and tolerant for the times. He was generous with the fortune that the efforts of his merchant brothers secured to him; and one of his legacies was £30 "to the poore of Christ hospitall in Smithfield." It is possible to doubt a few of Mr. Keynes' assertions, as for instance that Harvey's distended temporal vessel was a vein (especially if he is thought to have been hypertensive), or that his "olivaster" complexion suggests a Gallic rather than a Celtic ancestor. But such disagreement only emphasises that these two graceful studies of a great man are lively and imaginative, as well as erudite.

G. C. R. M.

NEW YEAR HONOURS

C.B.E. (Civil Division)

Clifford Viney Braimbridge, M.V.O., M.B., B.Chir., F.R.C.S.(Ed.), Colonial Medical Service, Senior Surgical Specialist, Kenya.

Frederick Tavinor Rees, M.C., T.D., M.R.C.S., L.R.C.P., Director-General of Medical Services, Ministry of Pensions.

O.B.E. (Civil Division)

Charles Elias Reindorf, M.D. For public services in the Gold Coast.

CORRESPONDENCE

MACKENZIE'S

To the Editor, St. Bartholomew's Hospital Journal

Dear Sir,

More reminiscences of Mackenzie's:

In my case a warning by a potential criminal against the police might have been more appropriate.

On an April evenig in 1904 it was my turn for the next case and I proceeded to No. 10, Rahere Street—off Goswell Road—the side streets of which—particularly Bestwick Street—were known as the abode of criminals.

I had been in and out of the house attending a "primip." By about midnight there was still "nothing doing" so I left the house for a "breather." When I reached Carter Paterson's Depot at the end of Goswell Road, it began to pour in torrents so I took to my heels and ran for shelter of some sort. There was a shop doorway at one of the corners and I had scarcely squeezed in when two stalwart City policemen seized me by wrists and shoulders and dragged me across the road to a street lamp. They were admonishing me in their usual stentorian tones "to come along quietly" and were about to clap handcuffs on me when, regaining my breath, I suggested they should send for a doctor from Bart.'s to take over my case.

Fortunately, one of the policemen had seen me entering the house earlier in the evening, and when I gave him the address and suggested he should check the articles in my black bag they let me go after the most humble apologies. The criminal whom they had been shadowing must have laughed up his sleeve, as I had apparently crossed his track.

Although there were plenty of abnormal presentations, the cases* in the three months from October 1 to September 31, 1907 showed not a single case of puerperal fever, thus agreeing with W.G.W.'s reference. The only catastrophe was a pph when the mother was moribund when the midwifery clerk arrived. In a serious case of this sort the Extern was instructed to send to the Hospital for the Physician-Accoucheur—Dr. Herbert Williamson at that time—and the Emergency Bag. This contained nothing more than two sheets, a pillow case and a couple of towels!

*Total: 299

Yours faithfully,

M. B. R.

Timber Hill,
Ashstead.
October 17, 1950.

THE BORDERLANDS

By DAVID CARRICK

THE little man who collected the pots in the "Green Dragon" was of grotesque appearance. Well below normal height, wizened, and possessed of a Punch-like nose, he resembled something out of a Grimm's Fairy Story or one of the more obscene characters from the Tales of Hoffmann, rather than a human being. But he was efficient, nobody could deny that: the very instant a customer had placed an empty glass on the table, the little creature would snatch it with a gnarled hand and scuttle off into his gloomy den at the back of the inn.

New customers regarded him with curiosity and perhaps revulsion: women avoided the place as they said he made them feel nervous: knowing the publican, I imagine that the latter fact may well have been the reason for his employment. But the regular customers looked upon him with a mixture of pity and amusement, for they knew his story.

Many years before, he had been certified insane and sent to the nearby asylum where he had remained as a patient for a considerable time. At length it was decided to give him his freedom, but he had grown so fond of the place that he refused to leave. The authorities, realising that his chances in the outside world were slight, kindly allowed him a bed in return for little odd jobs around the place. The only time he ever came outside was when he worked at his pot-collecting at the "Green Dragon."

Apart from any failings he may have had from the æsthetic point of view, there was much in his favour to suit such a job as his. He was as polite as possible, in no way aggresive, and, above all, never said a word even when the tipsy wags tried to pull his leg. So profound indeed was his silence, that I believed him to be a mute until one memorable evening.

It was a Saturday night. The pub was crowded. Some of the customers, who were very much the worse for wear, became involved in a heated argument with each other about something of trifling importance. In and out amongst the seething mass weaved Chico, as he was called, serenely indifferent to the turmoil until his progress was suddenly arrested by the application of a thumb and finger to the pinna of his right ear.

His captor, a large and burly navvy, winking at his laughing companions and antagonists, asked the wretched victim for his views on the subject, to which the poor fellow managed to whisper, diplomatically, that he agreed with all that his custodian had said.

"There y'are, boys," chortled the navvy, "if old Chico agrees with me, I must be right!"

Chico was very pleased at the acceptance of his wisdom and at his new-found popularity, and returned to his work. One of the navvy's opponents, however, disgruntled at his discomfiture and wishing to turn the laughter away from himself, shouted at the navvy: "Well, Mate, if that's the place yer get yer learning from, I reckon you're as mad as he is. Look at 'im; blooming idiot; chump; daftie; escaper from a Bughouse!"

There was a crash of breaking glass. The room was in silence as all eyes turned on Chico who was standing bowed down, with murder in his piggy eyes, the tray and six glasses broken at his feet.

For a time he stood like this. Then he became as a thing possessed. He jumped up and down, threw his arms about, and spat and swore like an angry ape.

"Mad am I?" he suddenly squeaked, still leaping about, and feeling in his pockets. "So it's daft I am. Well, we'll see about that, Mister Clever, just you look at this and see if I can't prove that I'm the only one in this room who ain't mad!" and he thrust a grimy piece of cardboard under his enemy's nose.

I never saw the document myself, but I was told that it was a certificate stating that its owner was sane. It was probably some joke on the part of a doctor done to please him, but, at all events, it certainly had the desired effect on those who read it, for, not only did a few have the grace to apologise, but ever afterwards he was treated with more respect and even occasionally to a free beer. He had gained his position in society.

Now this story can be regarded as a quaint little anecdote, or, on the other hand, as a parable, for a closer consideration of the material may reveal that a very important question is raised, namely, whether it is easier to prove oneself sane or insane. A hundred years ago, when people were not quite so clever, the problem hardly existed:

a man was either mad or he was not. To-day, when the world abounds with learned, and not so learned men who profess themselves able to divine the veriest degrees of stability, only the most obvious lunatic can be sure of his position.

Psychological and aptitude tests are becoming a rage. If they make as much ground in the next decade as they have done during the last, there may well come a day when even road-sweepers are subjected to tests as to their temperamental approach to wielding a broom, and meat-porters a carcase: such a state of affairs is by no means inconceivable in this enlightened age. It might be argued that these tests have no bearing upon a person's degree of sanity, only his intelligence, but it is a moot point as to where one begins and the other ends.

For example, consider those tests devised during the war for assaying a subject's aptitude for flying. When I was forced to participate in the game I was fortunate enough to be faintly intoxicated at the time and therefore did rather well. A companion of mine, however, who was not in such a happy frame of mind, failed miserably. He acquitted himself reasonably on the more difficult tests: the easy ones floored him. On being asked to assemble a machine so elementary that even I had no difficulty, he confessed himself beaten after five minutes: he was incapable of even beginning the task.

This failure depressed the man. For weeks afterwards, until he was posted, he never seemed the same. We tried to convince him that the incident was of no importance, but he would not see it that way: he had failed; there was a slur on his character. You see, in civil life that man had been an expert at assembling taxi-meters. Perhaps the test was too easy: it was certainly fallible, and it raised serious doubts in the mind of a normally placid individual.

Another case in which all the experts and all the tests and machines were baffled occurred at a later stage in the war.

There was a certain pilot at a certain aerodrome. He was brave, happy, carefree, and apparently in perfect health, but he developed a peculiar obsession: he became enamoured of a sandwich. It was a commonplace, everyday paste sandwich, just the sort of thing perpetually displayed beneath glass domes in railway buffets, and just as decrepit; yet he professed to be fond of it. He took it wherever he went at the end of a piece of string: he never let it out of his sight, not even at night when it reposed on the pillow beside his head: it is alleged that he even bought beer for it, but its desiccated appearance belied the story: he called it Cuthbert.

Although treated as a joke by his companions, the strange alliance was severely questioned by the authorities: the appearance of an officer on parade trailing a sandwich behind him was considered bad for the discipline of the other ranks.

Naturally enough it was thought that, although he himself evinced no desire for it, he was trying to work his ticket, and strenuous efforts were made to unmask his cunning. However, his affection proved too strong for all the experts and both he and his friend were discharged.

Sceptics may regard this story as an exaggeration; they might even be right; but, at the same time, many a man was discharged from the Services under conditions just as strange and where the patient—or pretender—was the only person who had any idea about the true state of his mind.

To criticise always, and to praise never is the sign of a narrow mind, so I must close by recounting a singular adventure that befell a friend of mine that goes a long way to prove that the marvels of applied psychology can sometimes succeed where all else fails.

Brown, as I shall call him, had injured his elbow getting out of an aeroplane. He said that it gave him a great deal of pain at times, particularly in the evening when he used it most: yet nobody could find anything wrong with it. Relays of doctors examined and X-rayed it with no result. They all said that it was perfectly all right: any pain that he said he had must be a figment of his imagination. He nevertheless persisted in complaining, and at last it was decided to send him to a psychiatrist in the hope that he could do something, but they artfully omitted to tell him the nature of his destination: it would be a nice surprise for him.

Being a wealthy young man he was the proud possessor of a car. It was a huge and roomy vehicle but, unfortunately, not very reliable. In the normal way he took a preponderance of passengers as a precaution against the inevitable breakdown. On this occasion, however, he was alone, so it was with acute dismay that he heard the usual signs of trouble developing when he was within a mile of his goal. By the time he had

driven up to the entrance of the small mansion, the original faint knockings had developed into deafening explosions. Then when he stopped, so did the engine with an air of finality suggestive of death.

As he was sitting quietly thinking about this, a little Flying Officer came running down the steps towards him. He pranced up to the car, wrenched open the bonnet, peered inside, threw it down again, then, with a high-pitched laugh, said: "Something's wrong with that," and danced back into the building again.

My friend thought this was all a bit odd but was too concerned with the state of his car to consider the sinister significance of the incident, so he went inside to report his arrival.

He was asked to wait, which he did for nearly four hours, and it was nearly six before he was shown into the presence of a benevolent looking Squadron Leader.

After shaking hands, Brown proceeded to take off his coat as he had done so many times before. The doctor looked surprised and asked him what he was doing.

"I'm going to show you my elbow, sir," he replied.

"Show me your elbow?" repeated the doctor, with a perturbed look, "I don't think I really want to see that. Just you sit down quietly and we will have a little chat."

There was silence for a time until suddenly the doctor shot out, "Is your father a nervous man?"

Brown thought about it for a bit and then replied that he didn't think so, adding that it was unlikely because, as a young man he had spent a number of years training cannibals to plant coconuts.

Another silence ensued until the second question.

"Did you bite your nails as a child?"

"Yes, sir," was the reply, "did you?"

The doctor, hastily removing a nail from sight, laughed and agreed that he had done so on occasions.

And so the questions went on in a like fashion until both interrogator and examinee were quite fatigued. Finally, the doctor said that he was afraid that Brown had been sent to the wrong place and wrote an angry letter to those responsible.

Over an amicable cup of tea they discussed what my friend should do that night. His car would not go, the nearest town was miles away and there were no buses. The only thing for him to do was to sleep in one of the wards: a perfectly quiet one he was assured.

He found the ward which contained a dozen or so officers intent on a fierce game of solo with match sticks as currency. They evinced no interest in him so he went down to the common room.

The occupants here were more friendly and asked him what he was in for. His explanation about the car caused a good deal of merriment. They said it was the best one they had ever heard, and reminded each other to remember it. However, after a deal of trouble, which included a visit to the car, they said they believed him and he spent a pleasant enough evening which was only marred by the repeated warnings about nurses with injections. Once he allowed them to inject him, they darkly prognosticated, he really would be in for a stretch.

At ten o'clock he went to bed. To his surprise the lights were out: only a small blue bulb shed an eerie glow across the white beds and their occupants. The patient nearest to him was wide awake and staring at the ceiling, all the time muttering quietly to himself. Brown thought that a little light conversation was not out of place and whispered the observation, "Shocking place this, isn't it?"

The man sat bolt upright, glared malevolently and shouted, "Shocking place! Why? Why is it a shocking place?"

"Well," stammered Brown nervously, "there doesn't seem to be very much to do."

"There's plenty to do," came back the angry answer, "we have a film once a week, and during the day we have our handicrafts and sewing. What else do you want?"

Brown hastily agreed, apologised for running the place down, and added that he only wished that his own stay was longer. Then he quickly hopped into bed and pretended to go to sleep. Pretended was the word: what with keeping an eye open for the cruising nurses and listening to the noises of the sleepers and other wakers, the wretched man never slept a wink all night, and was only too glad to totter down to breakfast at 6.30, a worn-out wreck.

Breakfast was a merry meal. All went well until an argument arose as to the possibilities of financial gain in canning rabbits in Scotland. The argument quickly developed into a row for which he, who had never said a word, was blamed. He left his unfinished

breakfast and fled from the room amidst howls of derision, straight to his car which, with superhuman effort, he managed to push for nearly two miles before he judged himself fairly out of danger.

He tells me that his elbow never gave him any trouble again, and, what is more, never again will he complain of any illness unless verified by a thermometer: it was such a lesson to him.

EAST WING

The East Wing has now been opened with the following wards:—

Gynæcological Wards

Butlin	... ...	18 beds
Sandhurst	... ...	18 beds

Obstetrical Wards

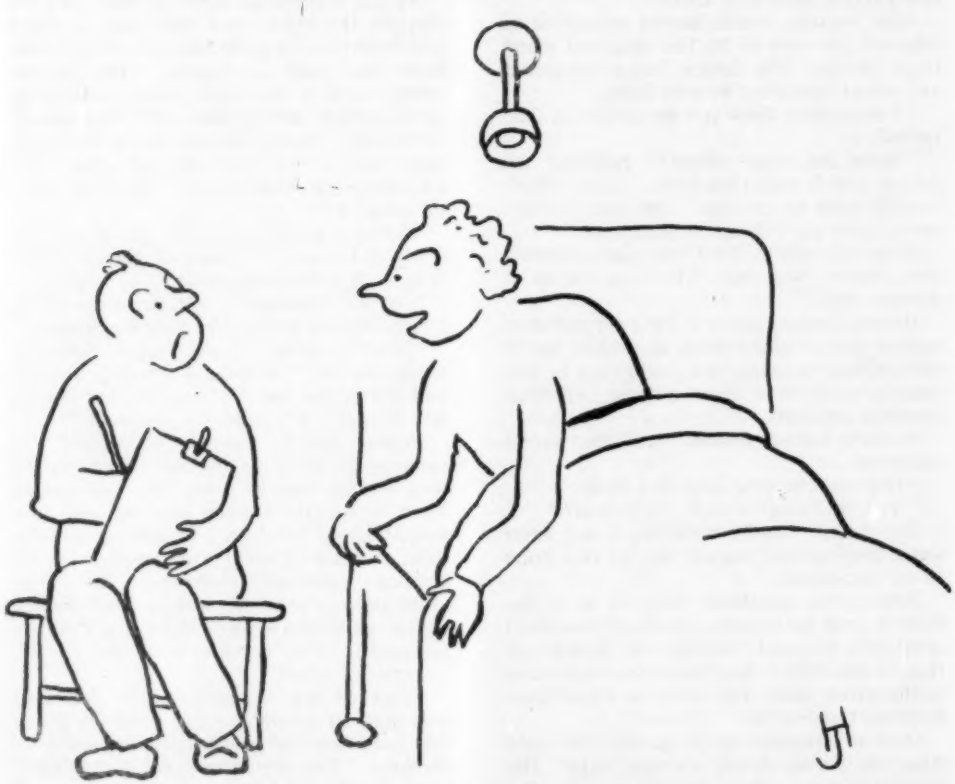
Elizabeth	... ...	18 beds
Martha	... ...	22 beds

Children's Wards

Kenton	... ...	24 beds

Physiotherapy Department

The four wards thus rendered vacant in the Main Block will be filled, after cleaning, by Mr. Naunton Morgan's firm and Dr. Spence's firm.



"I wasn't really well the day I was born . . ."

JIM SLOGGETT WALKS DOWN THE AISLE

By HERBERT PRANCE

ON a winter's morning in a year at the beginning of the century, I drove into a Cornish town to become partner to an old established practitioner. My attention was suddenly drawn to the sight of a boy, aged about seven, sitting on a board on the pavement and propelling himself by means of a stick in each hand. The pedestrians were accustomed to him evidently, as they just stepped to one side to let him pass and hardly looked at him. The excitement of introduction to my new environment put the matter out of my mind. One night after I had been in the practice about six months, I successfully turned and delivered a breach. The old midwife was no end pleased at my performance and said, "I wish you could see my little boy, I believe you would do him some good." When I saw him it was none other than the lad I had seen crawling along the pavement. It was an extreme talipes equinus. The nurse told me that all five doctors in the town had seen the boy, also a specialist surgeon from Plymouth, and all had told her that if they cut the tendon, the gaps left would be so wide that they would not join. My memory went back to Bart.'s orthopædic out - patients, when Willie Walsham called me up to state my treatment of a talipes. I said that I should be afraid to operate lest joining should not take place. The Surgeon said, "Never refrain from operating on that account; the joining will always take place."

What Walsham said was always Bible fact to me and I had no hesitation in telling the mother that I would put her boy's feet as they ought to be.

Accordingly I asked my old partner to give an anæsthetic but to my astonishment he refused and said it was very wrong of me to do an operation that had been universally turned down. Nor could I get any of the other men to lend a hand. Mrs. S., the mother, and all the family belonged to the Baptist Chapel and three of the girls were in the choir. The pastor of the chapel called and upbraided Mrs. S. for allowing this young doctor to "torture" her son when she had been told it was useless. The mother and family left the chapel for the Parish Church. I was on my mettle and decided to do it under a "local," with the mother as my assistant. This I did. Unfortunately the boy felt the prick of the needle in the second leg and set up a heart-rending howl, audible in the street and to neighbours. That put the cap on it. I put the legs up in plaster and departed. Many a time during the six weeks I gave it to heal I broke out in a clammy sweat, as I knew that failure meant a "finisher" as far as practice in that town was concerned. Imagine my ecstatic joy when I found the feet in excellent position and the tendon firm.

For a month after that mother and I secretly taught the boy to walk until he could make quite a good job of it. Then I decided after all I had been through, cold shouldered and cut for the last two months, I would get my own back. I had a talk with the sexton of the Parish Church and made him reserve two seats in a front pew for morning service on Easter Sunday. I then told a cab driver to pick up mother and boy and take them to the church just as the "Parson's bell" was finishing. Then mother and son—unassisted—would walk up to their front seats. It all come off according to plan and the people who for years had seen Jim crawling along the dirty pavement, saw him walk quite reasonably well up the aisle of the Parish Church. And what a change for me. I now became the talk of the town as "the clever young doctor."

Thank you, Mr. Walsham.

DEATH

We regret to announce the death of Dr. C. G. Martin, Deputy Medical Officer, Port of London Authority, aged 74.

SPORT

RUGBY CLUB

January 4, v. Leeds Medicals (home). Won 15-3.

Main credit for Bart.'s victory in this delightful game at Chislehurst was due to the individual attacking prowess of the backs, and to the very fine display of V. G. Caiger at full back.

The forwards, opposed by a good Leeds pack, were energetic enough in the loose, but seemed to lack that cohesion necessary to feed the backs as often and as cleanly as they should.

Bart.'s opened the scoring in the first half when Porteus, after a fine run, scored far out. This was soon followed by a similar effort by Davies.

In the second half Mears pounced on a Leeds mistake and cleverly sent Porteus over the third try. The fourth try was scored by A. H. John. A fine penalty goal by Leeds was followed by the most spectacular incident of the match. Fielding a miskick by a defender, John found himself hemmed in near the touchline. Unperturbed, our hero sold one of his famous "dummies" to create a gap for him to stroll nonchalantly over for Bart.'s final try.

January 7, v. Old Rutlishians (away). Drawn 3-3.

One penalty goal each was the score when St. Bart.'s Hospital drew with the Old Rutlishians in a thrilling match on the Old Boys' ground this afternoon.

The Old Rutlishians were first to take the initiative and pressed hard for the early part of the game, but by half-time Bart.'s were looking really aggressive and continued to improve throughout the second half. Gaskin converted a penalty for the Old Boys half-way through the first half, and Davies did likewise for the Hospital in the early part of the second half.

M. J. A. Davies, the master-mind of a much-improved line of Bart.'s backs, was in devastating form; K. A. Clare at fly-half also looked dangerous and his kicking was good, but he tended to hang on to the ball too long, with the result that wings did not receive the opportunities their talent deserved. At full back V. G. Caiger was outstanding; his fielding and tackling were faultless, and rarely did his kicks fail to find touch.

The Bart.'s pack were in great form. The hooking of P. D. Moyes enhanced even his reputation, whilst A. H. John was a tower of strength in the line-outs. D. G. Dick was active everywhere, spurring his fiery forwards to even greater efforts.

It was indeed a game full of thrills, and also a most encouraging improvement in the Bart.'s side. The forwards are now playing together as a pack, and the backs are becoming constructively aggressive. The game was clean, fast and open.

January 21, v. Bedford. Lost 0-17.

The Hospital were beaten by Bedford on Saturday, January 21, by 1 goal, 1 try and 3 penalties (17 points) to nil. The game as a whole was rather disappointing after the performance against Cheltenham. Bedford scored in the first two minutes with a try by their right wing after a quick heel from the loose and a cut through by the stand-off. Seven minutes later this was followed by a try by the left wing after another break through by the stand-off. This was converted, and the Hospital were eight points down before they realised they were on the field. However, after this disastrous start, our line was not crossed again, though Bedford's score was increased by three good penalty kicks. The outstanding feature as far as the Hospital was concerned, was the brilliant hooking of P. D. Moyes and the grand tight scrummaging of the rest of the pack. In the loose A. J. Third, R. Heylings and G. Mears were outstanding, and C. W. H. Havard did some good work in the line-outs. Of the backs, both centres, K. A. Clare and J. K. Murphy, found gaps in the Bedford defence, and the wings, R. F. M. Jones and G. Picthall, had some good runs and always looked dangerous when given a chance. Too often, however, wild passes ended promising movements, and the centres had to make hurried kicks ahead because they received the ball a little too late to allow them to do otherwise. At full back G. Small played extremely well, his fielding, kicking and tackling being most encouraging.

If only the team can cure themselves of that fatal lethargy of the first ten minutes, which in previous matches has cost them so dear, we should win our remaining matches.

January 14, v. Cheltenham (home). Lost 0-9.

Against a team containing two Internationals, two Cambridge Blues and five County Players, Bart.'s put up one of their best performances of the season. Cheltenham have not been beaten in England yet, and a keen game was anticipated: our supporters were not disappointed.

Bart.'s took longer than the visitors to settle down, and, after a quick heel from a scrum on our line, an opposition wing forward dived over and scored in the first five minutes. The game then speeded up and the battle between the two packs was rough and boisterous. There was very little in it in the line-outs and loose scrums, but we had a definite advantage in the tight. In a game in which all the players were good, it is difficult to pick out individuals; however, P. D. Moyes must be mentioned for his faultless hooking. He was ably supported by a pack who let the ball out quickly into the hands of an eager scrum-half.

The battle between the three's was similar in intensity. Tackling was vigorous in defence, and our attack was wholehearted in determination. We still must develop penetration, however, and then we shall indeed be on top.

Our visitors' second try came just before half-time. The two sides were evenly matched in the second half, with Bart.'s coming near to scoring half a dozen times and not quite making it. The visitors scored their third try in the last minute of the game.

HOCKEY CLUB

January 7, 1st XI v. Vauxhall Motors (home). Lost 1-4.

January 14, 1st XI v. Staines (away). Won 2-0.

Our first fixture against Staines was played on a slippery, uneven surface. The home team, fresh from a 4-0 win against London Hospital the previous week, attacked strongly from the start, but was kept at bay by the backs, of whom Ross was clearing the circle with particular severity. The Hospital forwards, with Dossetor at inside-left, always looked dangerous, and it was no surprise when Godden finished a spirited run with a beautifully angled shot.

In the second half Staines combined well in mid-field, but wasted several good scoring chances. Haigh, in goal, made several notable saves, but his technique of catching the ball between his thighs and hopping towards the goal line seemed open to question, if only for reasons of personal safety. Bart.'s settled the issue with a goal by Dosseter, who tricked the entire defence in a brilliant solo run from his own half.

January 21, v. R.N.C. Greenwich (home). Lost 3-4.

This match proved to be one of the best of the season so far. The Hospital opened the scoring with a goal by Batterham. R.N.C. quickly took advantage of defensive lapses to score twice, but Dosseter equalised just before half-time.

Both sides went all out from the restart, and Bart.'s soon took the lead through Batterham, who ran through and beat the goalkeeper in convincing style, only for R.N.C. to equalise from a long corner.

The College were a little fortunate to score the winning goal off a defender's boot, and spent the last ten minutes desperately defending their goal from the furious onslaught in which the Hospital did everything but score.

January 28, v. N.P.L. (home). Won 1-0.

January 7, 2nd XI v. Vickers, Crayford (away). Lost 0-7.

January 14, 2nd XI v. Inland Revenue II (home). Lost 1-3.

January 21, 2nd XI v. Peak Frean (away). Lost 2-4.

January 28, 2nd XI v. N.P.L. II (away). Lost 1-4.

CROSS COUNTRY CLUB

Bart.'s has not enjoyed a successful cross-country season up to the time of writing. New members have not been forthcoming and with A. Dormer, A. Macdonald and J. Stainton-Ellis all suffering from injury we have often had difficulty in raising a team. John Menon has now qualified and we wish him every success. Menon has been the undisputed United Hospitals' cross-country champion for three years, and he was always a tower of strength in the longer track events. The Athletic Club will be the poorer for his absence.

With the return of Dormer and Stainton-Ellis, however, we expect that the New Year will see a reversal of fortunes: although, at the risk of repetition, it is painfully obvious that new members are still urgently required.

October 29, v. Orion Harriers. Away. 5 miles.

This fixture was held in conjunction with the United Hospitals' match versus the Orion. It proved a most enjoyable run, the Orion emerging victors by a narrow margin.

Leading Bart.'s positions:

2nd A. Macdonald.
5th J. I. Burn
7th J. A. Menon
10th G. Wallace

1. Orion—36 points
2. Bart.'s—42 points

November 26, v. Shaftsbury Harriers. Away. 5 miles

Bart.'s were well beaten—deservedly.

Leading positions:

3rd J. I. Burn
7th G. Wallace

1. Shaftsbury—18 points
2. Bart.'s—37 points

November 30, v. Guy's Hospital v. L.S.E. Home. 3¼ miles.

This was our first home match of the season, although we had previously entertained members of the United Hospitals' in the Club Handicap race. The Bart.'s tail wagged merrily, but J. Barnes lost his way and Guys had beaten us for the first time in ten years.

Leading Bart.'s positions:

1st J. I. Burn
3rd A. Macdonald

1. L.S.E.—31 points
2. Guys—44 points
3. Bart.'s—45 points

December 3, v. London University Championships Roehampton. 4¾ miles

This fixture always lacks the friendly atmosphere that one associates with the inter-club races. With titles and honour at stake tempers are often frayed and not a few are truly glad when the meeting is over.

This proved to be an exception, however, and a most enjoyable afternoon was experienced. We had no illusions as to our chances in the event, and were well pleased to obtain 15th position out of some 30 competing teams. It was gratifying to see the newly formed London Hospital team occupying 5th place.

Leading Bart.'s positions:

23rd. J. A. Menon
27th J. I. Burn
34th A. Macdonald

RIFLE CLUB

"It was not always so"—might well be said of the club as it finds itself today, for the past six months have seen a big change. Firstly, we have the use of the hospital range again which allows us a great many opportunities which we lacked at the Cripplegate Institute. Then we also have new rifles and telescopes and as a result most people's scores have improved appreciably. Lastly, but probably the most important factor has been the hard work put into practising by the team members.

The "A" team has not been beaten by any college team entered for the Engineer's Cup and 9 out of 13 matches have already been shot. A year ago it must be said, not a single match was won. The following have averages over 95:

B. D. Lascelles ... ... 98.2 (match av. 97.3)
J. S. Bunting ... ... 96.4 (match av. 96.7)
G. C. R. Morris ... 96.3 (match av. 97.3)
J. F. Craddock-Watson 96.2 (match av. 95.8)
M. C. Wall ... ... 95.7 (match av. 95.8)

B. D. Lascelles won the scratch competition for the Lady Ludlow Cup with a score of 99. He has obtained five possibles this season (though still none in matches) and shoots for the Univer-

sity "A." The University "B" team contains three from Bart.'s including its captain M. C. Hall.

Once a month we have been holding prize meetings run on a handicap basis and these have been very popular. H. G. Scott won the November Tankard prize with 94 (+6 handicap) and C. M. Vickery won in January with 96 (+4 handicap)—2nd prize C. J. R. Elliott, 3rd prize R. J. Johnson.

The "B" team has now several safe shots in reserve so that it should be able to enter for the Engineer's Cup next season and make a good showing. It has beaten University College "B" and when given 25 handicap beat the "A" team by a good margin. The highest averages in the "B" team are:

M. B. McKerrow—92.6
C. D. Ellis—92.6
F. P. Thoresby—92.0

Bisley

During the months of May and June it will be possible to take up to 15 members to Bisley on Saturdays. This season's full-bore shooting should be even more enjoyable than last for University and club matches will be more keenly contested and it should be possible to do some revolver and clay pigeon shooting in addition. There is a handicap and a scratch cup for competition and, of course, finally, the United Hospitals' Cup in which we were second to Guy's in 1949.

EXAMINATION RESULTS

ROYAL COLLEGE OF SURGEONS

Subject to the approval of the Council of the Royal College of Surgeons at a meeting held on December 8, 1949, the following are entitled to the Diploma of Fellow:—

Black, H. D. W.	Farrar, D. A.	Jack, R. C.	Rogers, N. C.
Block, J.	Flannery, B. P.	Mackenzie, A. B.	Roper, A.
Dingley, A. G.	Gabel, F. E. J.	Ramayya, G. P.	Ross, D. N.
Donaldson, I. A.	Henson, G. F. T. W.	Ramsay, G. S.	Todd, I. P.
Durham, M. P.	Higazi, H. E. S.	Ramsay, R.	Williams, D. O.
			Wilson, M. G.

UNIVERSITY OF LONDON

M.D. Examination — **December, 1949**

Branch I (Medicine)	Branch II (Pathology)	Branch IV (Midwifery)	
Anderson, A. W.	Story, P.	Champ, C. J.	

Examination for the Academic Postgraduate Certificate in Public Health — **December, 1949**

Adams, K. J.	Phillips, H. T.	van de Linde, P. A. M.	

Special First Examination for Medical Degrees — **December, 1949**

Batterham, E. J.	Clare, K. A.	Goss, G. C. L.	Stainton-Ellis, J. A.
Beasley, R. W. R.	Cranston, C. J.	Kirk, A. G.	Topham, P. A.
Carter, J. C.	Cunningham, G. A. B.	Macadam, F. I.	

The following Higher School Candidates have qualified for exemption from First Medical Examination

Allen, A. B.	Bott, M. M. L.	Graham, M. A. H.	Taylor, R. C.
Ashworth, E. J.	Canning, W. C.	Jones, H. D.	Wetherall, J. M.

CONJOINT BOARD

Final Examination — **January, 1950**

Pathology			
Cairns, I. D.	Godden, J. L.	Richards, R. B. O.	Wright, A. N. H.
Coldrey, J. B.	Jenkins, G. C.	Watkins, P. H.	Wright, R. F.
Dossetor, J. B.	Jones, J. N. W.	Willis, P. F.	
Medicine			
Abraham, R. J.-D.	Chorley, G. E.	Liu, S.	Wallis, F. P.
Baker, A. M.	Dossetor, J. B.	Mason-Walshaw, K. R.	Willis, P. F.
Brest, B. I.	Hibbard, B. M.	Rees, J. D.	Wright, R. F.
Burn, J. I.	James, D. C.	Rosen, I.	
Carter, F. G. T.	Lester, J. P.	Tannen, G. P.	
Surgery			
Abraham, R. J. D.	Chandler, G. C. H.	Hacking, S.	Rowson, K. E. K.
Baker, A. M.	Dossetor, J. B.	Hale, B. C.	Tannen, G. P.
Bhandari, N. P.	Gosling, R. E. G.	Rosen, I.	Willis, P. F.
Midwifery			
Cairns, J. D.	Hirst, G.	Moyes, P. D.	Vickers, R.
Dossetor, J. B.	Hodson, J. M.	Sacks, R. H. B.	Willis, P. F.
Godden, J. L.	Horwitz, H.	Smith, I. G.	Wright, R. F.
Hardy, C. G. J.	Lodwick, J.	Vercoe, M. G. S.	

The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P.

Abraham, R. J.-D.	Carter, F. G. T.	Lester, J. P.	Tannen, G. P.
Baker, A. M.	Dossetor, J. B.	Mason-Walshaw, K. R.	Wallis, F. P.
Bhandari, N. P.	Gosling, R. E. G.	Rees, J. D.	Willis, P. F.
Brest, B. I.	Hardy, C. G. J.	Rosen, I.	

BOOK REVIEWS

HANDBOOK OF BACTERIOLOGY, by J. W. Bigger. 6th Edition. Ballière, Tindall & Cox, 1949, pp. xvi + 547. Price 20s.

This excellent book does credit to its publishers. It is well produced on good paper with clear illustrations, and at a reasonable price. The chapters on general bacteriology are exhaustive but not wearisome in their length—the detailed illustrated description of staining methods and serological technique is to be commended. The chapter on the identification of bacteria is particularly valuable to the student. The individual bacteria are treated briefly but adequately—subheadings, however, would improve these chapters considerably.

OUTLINE OF ANÆSTHESIA FROM THE NURSE'S VIEWPOINT, by C. Langton Hewer. Hospital and Social Services Journal, 1950, pp. 24. Price 1s. 6d.

The theatre nurse will find practical information in a readable style and sensible presentation in Dr. Langton Hewer's pamphlet.

AIDS TO ANATOMY AND PHYSIOLOGY, by K. F. Armstrong. Ballière, Tindall & Cox, 1949, 4th Edition, pp. xii + 452. Figs. 192. Price 6s.

This is a fourth edition of a well-known book in the "Aids" series. Its diagrams are very good, but the X-rays to show normal function are poorly selected. A reversed picture of a barium enema has been chosen, the most striking point in the normal gall bladder picture is a group of stones. The mouth and oesophagus are not lined with transitional epithelium (p. 60), neither do elastic fibres have nuclei (p. 61).

THE NATURE OF DISEASE INSTITUTE, Second Annual Report, by J. E. R. McDonagh. Heinemann, 1949, pp. 188. Price 15s.

The foundation of this Institute by the author in 1927 was prompted by the desire to establish the view that what are known as "diseases" are no more than manifestations of the damage suffered by the protein in the blood of man. The basis of treatment is to wash out the large intestine, correct the osteopathic lesions to which the intestinal toxæmia has given rise, to restore the damaged protein in the blood to its normal chemico-physical state, and to immunise the patient against the activity of the micro-organisms isolated from the excreta. The First Annual Report (1948) opened with a discussion of the relationship between healthy and unhealthy soil, and health and disease in plants, animals and man; the Second deals with disease in plants. Both contain physico-chemical, microbiological and clinical sections.

The terminology of these Reports is largely private to the author, and any relationship of his theories to orthodox medicine is coincidental. The coming publication of a Third Annual Report promises to complete a trilogy which will be interesting to students of medical heresy.

DISEASES OF WOMEN, by Ten Teachers. Edited by Clifford White, Frank Cook and Sir William Gilliat. 8th Edition. Arnold, 1949, pp. 461. Price 25s.

The systematisation of gynæcology allows ten distinguished exponents of the speciality to write a coherent text-book, without duplication or contradiction. And it is right that a text-book for students should present the consensus of the best current opinion. That variations from this opinion are possible the student will soon discover in the clinical teaching of this hospital, and in particular he will need to acquaint himself with recent advances in theory and technique not yet uniformly acceptable. These reservations do not detract from the value of this concise and well-cogitated basic text-book, which has been thoroughly revised in the seven years since the last edition.

A SHORT HISTORY OF PHYSIOLOGY, by K. J. Franklin. Staples Press, 1949. 2nd Edition, pp. 147. Price 10s. 6d.

The progress of physiology, slow for centuries, has been very rapid recently. The work of the twentieth century can not yet be assessed in a historical context, and Professor Franklin's chapter on the nineteenth century reveals how difficult it is to weave a continuous pattern from the multifarious threads of modern research (and the vital strand of the genetic theory of evolution, as important to physiology as the discovery of the microscope, is omitted). The less familiar early history, from Alcmaeon to Fernel and William Harvey, is admirably set out, and gives a good perspective view of the background to the scientific investigation of animal physiology. The book has been redesigned to good effect, and decorated by sixteen portraits of the great.

THE COMMON INFECTIOUS DISEASES, by H. S. Banks. Arnold, 1949, pp. 354. Price 21s.

All who have had the benefit of Dr. Banks' teaching at the Park Hospital will be delighted to see in print the results of his extensive experience of "fevers." The book is founded, as is only too rare, on personal clinical observation, and embodies a large number of advances in management for which the author is responsible. Each disease is presented freshly and in admirable detail, with a critical appraisal of the literature; so that the post-graduate will find the answers to most of his queries, and yet the student will not be overwhelmed. The relevant technical procedures are carefully described in the appropriate places, and a number of valuable practical hints are incorporated.

Some of the illustrations show too clearly the difficulties in the way of half-tone representation of skin. Idiosyncrasies of phraseology, the use of italics for emphasis as well as cross-headings, and such misprints as "intake of fluids by mouth and parentally" will no doubt be ironed out in subsequent editions of what should become a very popular text-book.

ESSENTIALS OF ORTHOPÆDICS, by Philip Wiles. J. & A. Churchill Ltd., 1949, pp. xvi + 486, 7 colour plates and 365 text figures. Price 42s.

The paucity of orthopædic text-books points to the difficulty of presenting a subject which is undergoing rapid change and in which there is a correspondingly healthy diversity of thought. A text-book like the present, with its freshness of personal experience and personal opinion, must reflect the whims of the author unless he is to fall into the trap of discursiveness. Mr. Wiles expresses his views with a dogmatism which should please the most exacting examinee. The soundness of most of his views is sufficient justification, but there are errors which are perhaps emphasised by such an approach. Sterno-mastoid tenotomy for torticollis should not be performed as early as possible, but as early as the patient is able to co-operate in after-treatment; spondylolysis is not a failure of fusion between the centres for neural arch and vertebral body, but between two parts of the neural arch; anterior fusion for spondylolisthesis, a dangerous operation, has not been condemned without fair trial; arthrodesis of the foot as early as the age of eight years leads to much avoidable crippling; heel wedges as high as a quarter of an inch are intolerable; osteoarthritis is not the perquisite of diarthrodial joints; in acromegaly the ribs grow in length as well as thickness; the ratio of lateral meniscus injuries to medial is not about 1 in 10 but 1 in 3 or 4. It would be a pity to stress such errors in so good a book, and they will doubtless be corrected in the succeeding editions which will assuredly be asked for. The book is intended for general practitioners, undergraduate students and junior post-graduates, for all of whom it will be useful as a text for the cases which they see and as a basis for practice. The text is pleasant and easy, and the illustrations exceptionally good.

H. J. B.

INFANT NUTRITION. Its Physiological Basis, by F. W. Clements. John Wright, 1949, pp. vii + 246. Price 21s.

Infant feeding is, and has been for many centuries, an art; infant nutrition on the other hand is a science, born at the end of the 19th century. This comprehensive book is written by an Australian who has collected most of the relevant facts published in the last twenty years about fœtal and infant nutrition. Part I deals with tissue metabolism, Part II with fœtal nutrition. Part III with the properties of human and cow's milk. Part IV with digestion, and Part V with infant nutritional requirements. In Part VI he deals with the clinical application of the vast amount of data compiled in the preceding sections (there are over 600 references), but it is sketchily written and on the whole disappointing. It is impossible to check the accuracy of the scientific data, but there is a reference to Sir Wilfred Sheldon which suggests that that eminent pædiatrician's reputation is even higher in Australia than it is over here.

As a reference book on infant nutrition, this is unique and research workers should find it of very great value, but to the larger circle of doctors and nurses practicising the art of infant feeding, it will not be of much practical assistance.

I. G. W.

THE REMINISCENCES OF A PHYSICIAN, by Bernard Myers. A. H. and A. W. Reed, 1949, pp. 159. Price 10s. 6d.

Perhaps the most exciting thing about writing an autobiography is the opportunity it gives us to see our exploits over the years, purged of trivialities and resplendent in the gloriously rapid succession in which they appear to have occurred. Dr. Myers deserves this satisfaction, although he has been generous enough to include some of his less momentous experiences, such as organising unruly women at a rummage sale and being in charge of a detachment of St. John's Ambulance.

Authors are often so reticent that they hide behind pseudonyms or disguise themselves as characters in novels. This author, however, is to be congratulated on the intrepidity with which he has recorded his doings, thoughts and impressions. His philosophy appears both simple and warm-hearted, and is neatly summarised in a lunch-party conversation with a former Premier of Canada. When asked for his views on life, he replies that after forty years of practice, he believes that it is true to state that we all seek health and happiness, but by no means always in the same way. He had found that hard work—whatever the occupation—altruism, recreation, good health, good friends and a contented mind, paved the road to happiness. If the current Government acted wisely, that helped. Lord Bennett agreed.

This book is designed to interest the general reader. There are no bemusing technicalities. When the author introduces hypertension, he dismisses it again without embarrassment. ("Take, for instance, bood pressure. It may be normal, high or low . . .") We think that many such readers will be interested in reading this book, which is mainly about the author, his experiences and his distinguished friends. It should be of especial interest to all those who know the author personally.

VARICOSE VEINS, by R. Rowden Foote. Butterworth, 1949, pp. xv + 226. Price 32s. 6d.

This book covers the whole subject of varicose veins and gravitational ulcer of the leg. Although many authorities do not agree with his actual operative technique, that is, retrograde injection from the saphenous opening with scarification of the intima, the author nevertheless has a sound approach and covers the subject including an historical survey.

Particularly good are the chapters on investigation of the patient and on supportive treatment for ulcer. The production is good and the illustrations are well above average.

More recent work is referred to briefly in an appendix.

TEXTBOOK OF BACTERIOLOGY, by C. H. Browning and T. J. Mackie (11th edition of Muir and Ritchie's "Manual"). Oxford University Press, 1949, pp. 907. Price 50s.

The aim of a "a critical survey of knowledge up-to-date, along with an account of the basic information yielded by laboratory and clinical investigations" was consistent with a "manual" of bacteriology in 1897; forty years later the work was becoming unhandy; and now a revision of format and so of title has become inevitable. The scope of the book has been most conspicuously enlarged in the subjects of chemotherapy and

viruses, but every chapter has shared in an exhaustive reassessment of past experience and present theory. Nomenclature has wisely been left unchanged, but the still variable alternatives of "Bergey" are quoted. The bibliography is excellent.

The whole is a comprehensive review of the subject, far less formidable in the perusal than would be expected: a reference book and stimulus for the enquiring student, no less than a text-book for the bacteriologist.

A TEXTBOOK OF BACTERIOLOGY FOR DENTAL STUDENTS, by Arthur Bulleid and C. W. Shuttleworth. 3rd Edition. William Heinemann. 1949, pp. xvi+247. One coloured plate. Price 25s.

There have been considerable additions to our knowledge since the last edition of this textbook in 1937 and these are reflected in this new edition which has been completely rewritten and enlarged. The authors claim that it has been to some large extent modelled on the Textbook of Bacteriology by Fairbrother, and medical students will recognise the similarity. It is divided into three parts: the first dealing with bacteria in general, technical methods and problems of infection, the second with individual organisms and the third with the work more particularly confronting dental bacteriologists.

The book is handsomely printed on excellent paper, but it is a sad commentary on present day prices that it should be necessary to charge 25s. for it.

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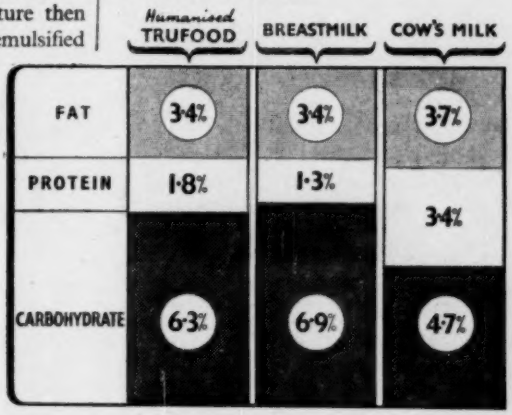

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